TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GREGORY P ENNIS MD

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-18-0002-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill was submitted timely and this reconsideration within 10 months pursuant to 133.250 TAC, we ask that you reconsider this billing. Please remit payment and interest as requested in the billing."

Amount in Dispute: $265.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and adjusted for payment – copies of the EOB is attached."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
October 20, 2016	99215 and 99080-73	$247.40	$0.00
October 24, 2016	S9982	$18.00	$0.00
TOTAL		$265.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for medical fee dispute resolution.
2. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment and Refunds.
3. Texas Labor Code §413.019 sets out the procedures for Interest Earned for Delayed Payment, Refund, or Overpayment.
4. Texas Labor Code §401.023 sets out the procedures for computation of Interest or Discount Rate.

Issues

1. Is the requestor disputing CPT Code S9982 rendered on October 24, 2016?
2. Did the insurance carrier issue payment for the disputed charges?
3. What is the interest per 28 Texas Administrative Code §134.130?
4. Is the requestor entitled to interest reimbursement?

Findings

1. The requestor's contact, Brian Shepler, indicated that disputed service S9982 identified on the "Table of Disputed Services" is not in dispute. As a result, the Division will determine if the requestor is entitled to interest for the disputed services rendered on October 20, 2016.
2. The requestor billed the amount of $247.40 for CPT code(s) 99215, 99080-73 rendered on October 20, 2016. Review of the CMS 1500 indicates that the disputed services were billed to the insurance carrier on July 17, 2017 and on August 25, 2017. Review of the submitted documentation supports that the insurance carrier issued payments totaling $247.40 on September 15, 2017. The requestor in correspondence to the Division confirmed receipt of the payment for the disputed services, however seeks payment for the interest not reimbursed by the insurance carrier.
3. The requestor alleges that interest is due for the service in dispute. Pursuant to 28 Texas Administrative Code §134.130(a) "Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.240 of this title (relating to Medical Payment and Denials). Review of the submitted information finds that the requestor billed the insurance carrier July 17, 2017 and on August 25, 2017, EOBs presented to MDR contain an audit date of August 16, 2017 and September 14, 2017. Review of the submitted documentation (EOBs) establishes that August 16, 2017 is the receipt date of the medical bill. The Division, therefore concludes that the date the carrier originally received the complete medical bill is on August 16, 2017.

   28 Texas Administrative Code §134.130(c) states, "The rate of interest to be paid shall be the rate calculated in accordance with Labor Code §401.023 and in effect on the date the payment was made." Review of the EOBs presented to MDR established that the date the insurance carrier payment was made is September 15, 2017.

   28 Texas Administrative Code §134.130 "(d) Interest shall be calculated as follows: (1) multiply the rate of interest by the amount on which interest is due (to determine the annual amount of interest); (2) divide the annual amount of interest by 365 (to determine the daily interest amount); then (3) multiply the daily interest amount by the number of days of interest to which the recipient is entitled under subsection (a) or (b) of this section."

   Review of the submitted information finds that the respondent reimbursed the requestor the amount of $247.40 for disputed services on September 15, 2017, within the 60th day after the insurance carrier originally received the complete medical bill. Therefore, per 28 Texas Administrative Code §134.130, the amount due for interest is $0.00.
4. The Division finds that the provider is not entitled to interest for the disputed services. As a result, the amount recommended is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 17, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.